מרכז רפואי ע"ש ברוך פדה, פוריה
The BARUCH PADEH Medical Center, PORIYA

מס' זהות:	
שם משפחה:	שם פרטי:
שם האב:	תאריך לידה:
כתובת:	
טלפון:	**מדבקת פרטי מטופל**

טופס הסכמה: ניתוח להסרת ירוד

CONSENT FORM: CATARACT EXTRACTION

Cataract is one of the common causes of sight disturbance in older people found in more than 2/3 of the population over the age of 60. Cataract is the condition in which the eye lens loses its transparency. The operation is intended to remove the opaque lens and in most cases to implant an artificial lens in its place. The type of lens and its optic power is determined by the physician according to details of the eye and the process of the operation. There are states in which it is not possible to implant a lens due to unsuitable conditions. In these cases cataract extraction alone will be performed. Cases occur in which absence of conditions for cataract implant will only become clear at the time of the operation. It may be necessary for some of the patients to wear glasses after the operation.
The operation is usually carried out under local anesthesia.

Name of Patient: _____ _____ _____ _____
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I received a detailed verbal explanation from:
Dr. _____ _____
Last Name First Name
regarding the need for a cataract operation on the left/right* eye with/without* an intraocular lens implant (henceforth: "the primary operation").

It has been explained to me that there are no alternative methods of cataract.

I hereby declare and confirm that I have received an explanation concerning the expected results, and the side effects of the operation including pain and discomfort.

In addition, I have received an explanation regarding the possible risks and complications during the course of the operation including: infection, bleeding, loss of the vitreous humor, dislocation of the lens, movement of the intraocular lens, complications associated with the late reaction of the eye to the operation and also the possibility of refraction problems after the operation, which may necessitate wearing glasses. In rare cases loss of sight may occur in the operated eye. Rarer complications are drooping of the eyelid, chronic inflammatory reaction, negative influence of the implanted lens on the cornea that necessitates removal of the lens by operation and sometimes a need for a corneal transplant, retinal detachment and macular swelling. Sometimes a secondary cataract appears needing treatment by laser.

I hereby give my consent to perform the primary operation.

I also declare and confirm that I received an explanation and understand the possibility that during the process of the primary operation the need may arise to change it or to undertake other or additional measures including additional surgical procedures in order to save life or prevent bodily harm that cannot be fully or with certainty anticipated at the time, but whose significance has been explained to me. I therefore consent to such an extension, modification or performance of other or additional procedures or operations, which the institution's physicians deem essential during the primary operation.
I also give my consent for the performance of local anesthesia after the risks and complications of the local anesthesia have been explained to me including: bleeding, infection, harm to the eye and in rare cases loss of sight.

יחידת עיניים

מס' זהות :

שם משפחה : שם פרטי :

שם האב : תאריך לידה :

כתובת :

טלפון:

מדבקת פרטי מטופל

If it is decided that the primary operation will be performed under general anesthesia, I will receive an explanation from an anesthesiologist.

I know and agree that the primary operation and any other procedure will be performed by whoever is designated to do so, according to the institutional procedures and directives, and that there is no guarantee that they will be performed, fully or in part, by a certain person, as long as they are performed according to the institution's standard degree of responsibility and according to the law.

Date _____ Time _____ Patient's Signature _____

Name of Guardian (Relationship) _____ Guardian's Signature (for incompetent, minor or mentally ill patients) _____

I hereby confirm that I provided the patient / the patient's guardian* with a detailed verbal explanation of all the abovementioned, as required, and that he/she signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

Name of Physician _____ Physician's Signature _____ License No. _____

* Cross out irrelevant option.